MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, September 9, 2004
10:36 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
JOHN M. BERTKO
FRANCIS J. CROSSON, M.D.
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
ARNOLD MILSTEIN, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
CAROL RAPHAEL
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Skilled nursing facilities: assessing quality
-- Sally Kaplan, Karen Milgate

MR. HACKBARTH: Sally and Karen are going to lead off with the discussion of skilled nursing facilities and tools to assess quality.

DR. KAPLAN: In this session, we discuss the Medicare's program current ability to assess quality for skilled nursing facility patients. Currently, except for three indicators on CMS's website, most information on SNF quality is not specific to short stay patients, the Medicare patients. Yet experts tell us that because the goals of care are so different, it's important to collect information specific to these patients.

In this analysis we are looking at what is available to measure quality, and whether this information captures the concerns about quality for SNF patients. First, we'll describe the important differences between short stay patients and long stay residents of nursing homes. Then we will describe the currently available quality indicators, including their limitations. Finally, we will discuss other types of information experts told us would be useful for measuring SNF quality.

For this analysis, we interviewed CMS representatives, industry groups, researchers, clinicians, quality and quality improvement experts.

One big question is why is it important to collect SNF-specific quality information? Generally both SNF patients and nursing home residents are in the same facility but the patients, the goals of their care, and the care they receive are very different.

This table shows some of the differences between SNF patients and nursing home residents. Medicare SNF care is always post-hospital and involves daily skilled nursing or rehabilitation care. Nursing home care is not post-hospital and it is custodial or non-skilled care. The goal of SNF care is recovery or improvement to the patient's highest level of functioning. The goal of nursing home care is maintenance of functioning to the extent possible.

The average length of stay for SNF patients is 25 days. In contrast, the average length of stay for nursing home residents is two years. On average, SNF patients make up 8 percent of a nursing home's patients. Nursing home residents make up the remainder.

Most facilities have designated all of their beds as SNF beds, but SNF patients fill only a few of those beds. The average facility has seven short-term patients and 84 long-term residents. Half of nursing homes have five or fewer SNF patients per day. Large national chains have a larger share. They tell us that up to one-fourth of their patients are SNF patients.

Given all the differences between short-term patients and long-stay residents, experts tell us that quality for nursing

home residents is not necessarily related to quality for SNF patients. The small number of SNF patients compared to long-stay residents has implications for patient care and quality and supports the need for collecting SNF-specific information.

Much of the research on quality makes no distinction between short-stay patients and long-term residents. But the Medicare program and MedPAC need separate measures for several purposes. CMS must monitor quality of care for SNF patients as part of their responsibility for the Medicare program. Implementation of a prospective payment system raises concerns about whether providers have incentives to improve or reduce quality under PPS.

Every year MedPAC assesses payment adequacy for SNFs and recommends an update to payments. Change in quality is one factor we use to determine if payments are adequate.

Finally, Medpac has recommended that CMS explore tying payment to provider performance on quality. Well accepted measures are critical to pay based on quality.

MS. MILGATE: CMS currently uses two sources of information on quality for short-stay patients in nursing facilities, first the minimum dataset and secondly, OSCAR, the Online Survey Certification and Reporting System. The first three indicators from the minimum dataset are also the ones that the National Quality Forum endorsed for short-stay patients in their process for looking at measures in nursing facilities.

The minimum dataset was developed primarily as an instrument to try to standardize the assessment process in nursing facilities, but has over time been used now for a couple of different purposes in addition. That is, for determining payment as well as for developing quality indicators.

For the short-stay patients, they are all assessed -- or the percentages of the residents that have the incidence of delirium, pain or the prevalence of pressure sores is derived from the 14-day assessment. So because it's derived on the 14th day the patient's in the SNF, that means, in fact, you lose some patients because some patients actually are discharged before the 14th day.

So the indicators look at, on the 14-day assessment, the percentage of patients that show symptoms of delirium different than usual functioning, the percentage of patients that report they have moderate or severe pain. And then for the prevalence of pressure sores, it's actually a change in time. They look at what the scores were on the five-day assessment. And if there was a zero and then it's progressed to a pressure sore, that's noted. Or if they had a level one or a level two, they see if it has progressed to a higher-level.

So those are the three primary indicators that CMS uses for SNFs.

The second source of information in OSCAR. This is information that's reported for the whole nursing facility. So again, you get some information that might be useful for short-stay patients but it's not broken out so it's unclear what the information here might mean for those short-stay patients.

In the OSCAR you have survey reports on deficiencies that

look at the severity of the deficiency as well as whether they were resolved. It also reports on complaints. And that there's also some staffing levels reported. And it's broken out by registered nurses, licensed practical nurses and certified nurse assistants.

Since the primary information comes from the MDS, we asked our expert interviewees to tell us a little bit about what they thought were the limitations of the MDS and to suggest some improvements, given that's a tool that is currently being used in nursing facilities. Here's what they said to us.

Because it was designed for long-stay patients, they suggested there's really too few useful indicators for short-stay where patients are expected to actually improve, which is a different way of looking at the patient, as Sally mentioned earlier.

While current indicators provide some useful information, they thought all of those areas were really important to measure, they said that there are some important ways that they're designed that might actually mislead those that are reading the information.

One example that struck me was that nurses are supposed to report a patient's actual experience with pain, whether they are on pain medication or not. But nurses are hesitant to code a patient on medication as not having pain. So they are nervous, the experts are, that in fact these are not being filled out correctly because the nurses don't want to say well, there's not pain but they're on some sort of pain medication.

Further, a high score on pain is supposed to indicate poor pain management, but several of our interviewees suggested that high scores could actually mean the facility is doing a better job at assessing pain. So this isn't to say that you shouldn't assess pain or you shouldn't look at pain management, but that they wonder if, in fact, this is the best way to do it.

In addition to looking at the substance of the measures, they say the timing of the MDS assessment also limits its utility. In particular, you need to have an assessment on admission and discharge. So while there is a five-day admission assessment, perhaps there should be one that's earlier than that so you can really look over time at what happens to the patient.

In particular there were concerns, though, about not having some type of picture of the patient at ad discharge so you could really look at what happened before the patient was discharged. They said, however, that this did not mean that there needed to be another assessment, an MDS assessment, but it could even be done on a tool that would be more specific to quality and have fewer indicators on it or fewer areas to fill out than the MDS actually did.

In terms of validity and reliability, there was a GAO report that did some digging into this and found that while on a national level the error rates for filling in the various sections of the MDS were 11 percent, that on the short-stay patient indicators, in fact, two of the three short-stay indicators had error rates quite a bit higher than that. So they questioned whether this would actually be an accurate picture at

the facility level, in particular.

There was 18 percent error rates for pressure sores and 39 percent for the moderate pain and 42 percent actually for the intense pain.

So we asked them, in addition or besides the MDS information that is collected, are there other quality concerns that they thought were important to be measured. These were the ones that really rose to the top, in terms of talking to our interviewees. I would say the first one was probably mentioned by about everyone we talked to and there was a couple of different ways. There was all rehospitalizations. And then there was also hospitalizations for conditions that really have been found to be associated with good quality of care or poor quality, depending on how you want to look at it. MedPAC actually used the rehospitalization for specific conditions in our March 2004 report when we were looking broadly at SNF quality.

The second one is discharge destination. This was looked at as an outcome which really captured a broad core of the types of things that need to be done for patients to reach their goals of care. Since so many SNF patients do have rehabilitation, one of the key goals of care is actually to go home. They said that looking at how many actually do go home, or where else they might have gone, was really a critical feature also of looking at quality in SNF.

The other was functional improvements. Again, this was kind of an over time look at how SNF patients did in their care. Again, because so many are getting rehabilitation services that you really should look at whether a patient has improved over time. This is really tied into the concern that there's no discharge assessment because there wasn't really an ability to measure over time. And then the fourth we heard was that it might be useful to start exploring the use of standard or best practice protocols for these types of patients. That while it was useful to look at the incidence, for example, of pain there might be a more direct way to actually look at the pain management process and if there were key processes that were actually being followed. Was the patient's pain actually assessed on a regular basis, for example. So they suggested we might want to start looking at that.

At this time, that concludes our presentation. We would ask you to give us feedback on the strategies that are suggested by these experts for obtaining better information on SNF quality.

DR. MILSTEIN: This list of potential increments appears to be very promising and likely account much better for quality of care. But some of them would not come at low cost. Were there any associated estimates of what the information collection burden might be associated with some of these measures?

MS. MILGATE: We didn't ask specifically the cost but the method for getting the information, for example, rehospitalization overall as well as for particular conditions, there are some programs that run on claims. I don't know how much the analysis of the claims will cost, but in terms of data collection burden it would not be high. And then the discharge destination is something where there also exist programs to look

at that.

The process, I doubt, would be a bigger project.

DR. MILSTEIN: The process and the change in functional standard, which I think would be the gold standard, would be not inexpensive.

MS. MILGATE: I don't know enough to say definitely about this, but there are some fields in the MDS already that look at functioning. So I don't know if it would be possible or not or a good idea or not to use those. As long as you had the discharge assessment, perhaps they could be used. But I don't want to say that definitively.

DR. CROSSON: I don't think I'm intemperate enough to suggest one quality measure over another and we probably would not finish the meeting today if we did that.

But I was struck by something. That was in addition to needing improvements in quality, needing to differentiate between SNF patients and nursing home patients or custodial patients, was the observation that in fact the SNF patients are admitted for some very different reasons. I think the distinction that was made was that some are admitted for functional recovery, presumably to get back to an independent living situation. Others for something that's more like comfort and palliation, individuals with a fatal disease. And a third category that is basically involved with medical stabilization, presumably to then be discharged to some other care setting, a lesser care setting including home care.

If that's the case, it seems to follow logically that if you're going to measure the quality for those three classifications, you ought to have quality measures that are in some way related to the difference in outcomes that are expected for those three groups. What those ought to be, I would not comment on.

But I do think the logic of the paper suggests that if that distinction is real and can be applied, then it kind of drives a quality measurement process which is relevant to those classifications and should start early in the admission.

DR. NELSON: I like the way your chapter is developed and I respect your use of your panel of experts to vet these items with.

But if may be that they were looking at things from a 30,000 foot level. As I took a look at the quality reporting on the SNFs in the area where I practiced and tried to determine whether they had discriminatory value in terms of which long-term care facilities I thought were good when I was in practice, and I could not get from the data the same kind of discriminatory information that I got as a practitioner when I either would visit patients there or hear from families or the patients themselves on their experiences.

So my comment is around a reality test of some of these data with a couple of focus groups comprised of discharge planners or physicians in a local area to get their ideas on how useful the quality reporting is and whether it either agreed with or disagreed with their ideas on the quality of the skilled nursing facilities in the area.

That may be far-fetched. It may not be practical or it might not give any information. Certainly you wouldn't want to use discharge planners from facilities that were attached to a SNF. But nonetheless, those folks do formulate pretty clear ideas on what's good and what isn't good in their local area. And I think that it would be really helpful if indeed they thought that there was some concordance between the quality data that are reported for these facilities and what their actual perceptions were from being on the ground.

DR. KAPLAN: Alan, your story is not an uncommon one, by the way. It is a story that I have heard a lot about, that I have heard a lot from various informants.

My concern is that one of the things that we're really trying to do is get at what is the quality of care for the SNF patient. I think what you are really talking about is to help consumers choose a nursing home, the consumer or their family or a professional perhaps, choose a nursing home.

One of the things we heard from every single one of the experts that we talked to was that quality for nursing home residents is not necessarily related to the quality of care that the SNF patient receives in that same place, that same facility. So I'm not sure we can really do both.

DR. NELSON: I have respect for what you say, Sally, and I would not argue with it. But some of these measures are so susceptible to interpretation, pressure sores for example. And the really best facilities in an area may look worse on paper because of superior identification and reporting. If indeed, there was some points of agreement between both of these directions, selecting a good facility based on its quality data to me isn't a lot different from measuring the quality within the home.

MS. MILGATE: I just want to say, Alan, that's basically what we heard from our experts is that the current measures, maybe they say something but in fact that there are some really limitations and they really should have some additional information to make an accurate decision about where to go or for Medicare to make an accurate decision about the quality of care of that setting.

So I think we found in our expert discussion, and maybe we did not make it quite plain enough or clear enough, that in fact they would agree with you 100 percent that the current information does not really give you enough to assess accurately.

But the other factor was Sally's, which is a lot of it is currently on the whole nursing facility so it is hard to ferret out for the short-stay patient.

MR. HACKBARTH: So to put this in context, last year we looked at ESRD and M+C. And in each of those cases we concluded that there were reasonable measures, a fairly strong consensus that there were good measures, the data were collectible, et cetera, et cetera. And we were prepared to move ahead towards using them as a basis for paying on quality.

Here, however, we have a very different circumstance. And I think the takeaway here is that our analysis and the experts say

that we really don't have a set of measures that meet those tests for the skilled nursing facility patients.

And probably on top of that there are issues about the measures used for the non-skilled patients, as well. But that is not the immediate question before us. So we have got a ways to go here. There is work to be done. We're not going to be recommending paying for quality at SNFS any time soon, I think is the bottom line.

DR. WAKEFIELD: You listed NQF's three measures that they were recommending for short-stay patients. When I read this, I was struck by the difference between that and your expert panel and the directions that they went. They seemed, to me, to really move in very different directions, expert panel focusing more on some process measures, et cetera. Just lots of differences.

Do you know whether NQF limited their scope of what they reviewed to just MDS? Or did they look outside of MDS, as well? Because I'm really struck by the difference here.

MS. MILGATE: They did primarily limit it to MDS-derived indicators because most of the information they were relying on for validity and reliability was information that had been done on MDS.

They did tell us though, because we asked them that question actually, they did say in their report that we really could use some more research and development of measures for the short-stay patients. They did not suggest that these three were sufficient in and of themselves. But these were the three that rose to the level that they felt they could recommend for post-acute patients in nursing facilities.

MR. DeBUSK: A couple things. I want to go back to the MDS. From my understanding, the MDS has never really been that successful. You've got 300 items to mark or what have you on that sheet. It seems to be voluminous in trying to do this job. But looking here at the quality concerns that could be measured, if you look at rehospitalization, discharge destination, functional improvement, those are after-the-fact measurements. That's after the incident has occurred. You go down to the use of standards or best practice protocols, that's the process. It looks like the place to go on the front end would be to establish the process and measure the process which ultimately is going to give you your outcome.

Is there a set of standards that exists out there now for nursing home?

DR. KAPLAN: Our experts tell us that there are some standards. I think we were looking at rehospitalization and discharge status and improvement in functional status as being outcomes, and then the processes being process measures, and not to use one necessarily to the exclusion of the other. But the process measures would take more work to develop. The others, two of them could be readily measured from existing data, and the change in functional ability, you would have to have a discharge assessment of functional ability.

MR. DeBUSK: It's almost like we've got to start somewhere.

MS. RAPHAEL: A couple of points. First of all, I believe that there is some overlap between the short-stay and the long-

stay patients and they're not always so clearly in one camp or the other, because people who are admitted for short stay sometimes end up staying for the 24 months or the 18 months. So I think we need to just be aware that the lines are not always clear. Even though we don't pay for the longer stay patients, I will say quality is more important when you're spending 24 months in a nursing home than if you are spending eight days in a nursing home. So I do not want to lose sight of that and we should be careful not to have two-tier systems here that we are contributing to creating.

For me, what I'm trying to grapple with is, if we take what Glenn posited that we are not ready for prime time yet here with the measures, the question for me is where do we go? Because we have raised issues overall about the efficacy of the classification and the payment systems for SNFs. We have talked about the need for redistribution toward the more medically complex, et cetera. So I'm trying to understand how we put this all together and where does this take us? And what could we begin to recommend that could help to move us toward a more effective way of purchasing services from SNFs? I don't really yet understand from all that you've done so far what you think might be a lever that could most help us to move along.

MS. MILGATE: Sally may need to answer that more broadly, but the purpose of this exercise wasn't quite that broad. It was more a matter of not just looking at the ability to do pay for performance but also monitoring of quality in general. That there just wasn't enough tools to do that, and that is was important for the Medicare program to have a better toolbox for measuring quality in SNFs.

Now what that would be used for is another question that I think you're raising more broadly, and what we feel like we got from our discussion and analysis was some suggestions for how you might be able to get some more information that would be useful. So it wasn't really at this point at least in a broader context.

MS. RAPHAEL: But if we are going to refine the systems that we have currently, shouldn't we embed some of this into any efforts to refine and collect data on patient status?

DR. KAPLAN: Your question is good and I think part of the whole thing is that most of the measures that we talked about, that we are thinking could be used to measure quality in a SNF are not necessarily specific to the existing -- there don't necessarily have to have the existing or have to get rid of the existing instrument. We're not really saying anything at this point about that. And they aren't necessarily related to one classification system versus another.

For example, if you've got a whole different classification system, these are still measures that you might want to have for SNFs. That is what our experts told us. This is what we would be concerned about for SNF patients. We started from scratch. We did not say, tell us about if you had the MDS or if you had RUGs. We said, what are you concerned about with SNF patients? So for the clinicians, they're in the SNF. They are not thinking about MDS or RUGs.

I think your question on payment is good. As you know, I

know I have been telling you this for five years, that there is a report that is due to Congress in January 2005, which is only a few months away on alternatives to the classification system. So I think I have to ask you on that question to ask you to be patient for a little bit longer, and hopefully we can get to that after that report is to Congress.

But I feel like this is part of that issue, but it is not just related to that issue. This is really just related to quality of SNFs. Yes, it is in the context of performance for SNFs. But if I tell you the real motivation of why I wanted to look at this was because I wanted something that we could use in our payment assessment analysis on quality. Every year we struggled to find anything that we can use to say something about change in quality for SNF patients. Not for NIF patients, not for the whole facility, but just for SNF patients. We struggle with that every single year. That is my first motivation. Then as we learned more then it moved into other areas. But that was first and foremost what I wanted to do was has something to say about SNF quality.

DR. REISCHAUER: Carol raised an issue that I wanted to ask, and that is if we have any information about the fraction of long-stay nursing folks who at one time or another where a SNF patient? I have three bits of anecdotal evidence from parents and parents-in-law, all three of which at some point in the nursing home were a SNF patient. I can see that the needs are different and all of that, but I don't know, maybe 75 percent -- I'm just making this up.

DR. KAPLAN: Seventy percent of patients who are admitted to SNFs go home.

DR. REISCHAUER: It's a very complicated thing that I'm thinking which is, during a lifetime or doing the last X years of life when people are in and out as a SNF, as a nursing patient, and you just track the same people, what fraction have this experience is what I'm wondering.

DR. KAPLAN: I don't think that information has ever been studied. I think there's information on what the odds are of being admitted to a nursing home, an institution. There's that information. Then there's information that 70 percent of the people admitted to a SNF go home. But there's not this other information that I think you're looking for.

DR. REISCHAUER: The other point I wanted to make was really the same one that Pete made. I was quite surprised, and maybe I should have known, that the MDS was as hefty an instrument as it is; 300 questions, 500 data points. I was wondering how many of these are things that don't change? This thing is filled out twice over the first two weeks, and how many of them are like address, or name of next of kin, or height, or things that are not likely to change, as opposed to something that would change.

And secondly, how long does it take to fill this out? If these were all changeable items which you had to get observation or information about, this is a day-long process to fill one of these out things out, it strikes me. I can't imagine that that much specific, different information is really necessary for whatever purposes this is point to, but I might be wrong.

DR. KAPLAN: As far as I know, nobody has done an analysis of how much changes from one assessment to another on the MDS, and I am not even sure that anybody has done anything on how often a group changes on the payment system, because that determines your SNF payment for that period per day.

The amount of time that it takes to do an MDS, memory is 2.5 hours, but I may not be exactly accurate about that.

MR. HACKBARTH: That is a comment that we have made in past reports, about the burdensome data collection, and we need to streamline and have common elements for different types of post-acute care.

DR. MILSTEIN: This discussion for me has some important generic elements that always underlie the question as to whether or not current measures are good enough to go forth or they're not good enough to go forth. Maybe I could just briefly comment on this.

It seems to me, if you categorize some of the comments made to date they really come out on different sides of the following balance. On one side of the balance is the value of delaying pay-for-performance until we have a good enough measurement set. On the other side of the scale, reflecting Carol's comments, is this implicit idea of the opportunity cost to American Medicare beneficiaries of being in facilities in which quality is not a basis of payment. Those two interests need to be weighed and sometimes there's a tendency to look at the inadequacy of measures and say, let's just wait. But I for one think we have to be equally mindful of the opportunity cost of continuing what has apparently been a multi-year tradition of lack of pay-for-performance.

Some thoughts I have on how this gets resolved in other situations -- and this is for the staff, a question of what is known about -- do we have any research evidence on the correlation in facilities ranked using today's highly imperfect quality set with a robust set? If there's any evidence to suggest that facilities ranked using today's thin set with a more robust set are reasonably good, then that would weigh on the side of the scale towards going forward with an early version of P-for-P rather than waiting.

The second thing that occurs to me is that we have some wisdom or an opinion on this expressed in Congress in its decision with respect to hospital pay-for-performance. If anyone were to step back and say, what percentage of hospital quality is captured by the 10 process measures that we are now not insignificantly rewarding hospitals for, it is not a very happy answer. I'm not sure it's a better answer than the current measures we have available for SNF patients in nursing homes.

So one way of essentially moving forward, if that's the side of the balance we decide we might want to act on or be relatively impressed by, would be to model that and, for example, suggest a P-for-P that's based on the SNFs collecting and reporting this more robust measure set that's been proposed. So then when we want to move to pay-for-performance in another two years we aren't bemoaning the fact that we are still where we were five years ago. Or deciding if there is reasonable correlation

between thin measures and good measures that is good enough, maybe not to go forward with plus or minus 20 percent, but maybe plus or minus 0.3 percent or 0.4 percent as a way of beginning to address the opportunity cost of having a quality insensitive payment system for nursing homes.

MR. HACKBARTH: I fully agree with your balance statement, your initial statement. Indeed in our past discussions of this, our past reports in congressional testimony, we've made much the same point, that there is a cost to the current system. The phrase that we've used over and over again is that the current payment system is at best neutral towards quality, and indeed often hostile. So people ought not feel comfortable with the status quo. There is a dramatic need to change, in our collective perspective, what we do here. So I think your statement fits quite well with where the Commission has been in the past.

Now having said that, I think there are some types of errors that are worse than others. So if we have poor quality measures, inadequate quality measures that create an incentive for people to do the wrong things with patients and further compound the problems that we have got, I worry more about that than measures that of wrong just in degree. They are pointing directionally in the right direction but it's just a matter of degree.

The way I interpret some of the discussion here is that in SNF care some of the measures might actually point in the wrong direction and reward behavior that actually we don't want to reward. I worry about that.

DR. MILSTEIN: I wonder if anyone can address the question of whether or not facility ranking using more robust measures is reasonably well correlated with facility ranking using these currently available less good measures. Because that would really help for me resolve which side of the balance I'd like to come --

MR. HACKBARTH: I think that is an excellent question. The begs though, do we have the comparison set? You need the more robust measures against which to compare.

MS. MILGATE: I do not think we can sit here and promise that but it is something that we could take a look at. For example, the rehospitalizations, we have run those before. We haven't done rankings and I do not know if rankings for the MDS measures are available to us either.

DR. MILLER: I think some of the fundamental question that we've brought up here to be discussed is, a lot of the conversations that occur here and out in the field is when people start talking about this, they're all talking about different things. You say quality of nursing homes and people start thinking nursing facilities. We're often talking about SNF. So the comparison that you're looking for, even if the analysis are done, are the measure sets that you would actually do that on, is there agreement on what those would be? Much less, has the work been done?

I think a fundamental point we're trying to lay out for you here is, we're starting to parse that distinction and we're going to pursuant it in a particular direction and trying if you agree

and whether that's the direction we're going to go in.

DR. MILSTEIN: What I'm suggesting is, there is a body of health services research on quality of care in nursing homes. All we have to do is find one piece of prior research using these more robust measures that occurred concurrent with, and focused on SNF patients as opposed to the nursing home patients, that occurred concurrent with a time when these less good but available measures were calculated. If you tell me that no such research exists --

DR. KAPLAN: There's a large body of research on quality for nursing home residents, long-stay residents. Usually the short-stay patients are excluded from that research, so there is nothing. The experts tell us that someone that ranks high on quality of care for nursing home residents is not necessarily going to ranked high on quality of care for SNF patients.

DR. MILSTEIN: The idea is, there is no such thing as a well-done piece of health services research that evaluates SNF patients within nursing homes with respect to any of these more robust measures of quality that the expert panel recommended. It's just never been done.

DR. KAPLAN: Exactly; never been done.

MR. DURENBERGER: I was going to suggest that maybe one of the reasons is we haven't fixed -- we are fixing accountability on institutions which largely are doing nursing home work, and they are doing some SNF work and so forth, as opposed to focusing the accountability for my health or my mother's recovery or whatever the case may be on a doctor, or on the hospital from which he or she was referred. All I want to do is plant a seed in the longer-term research that we ought not to be looking separately at the facility reimbursement but in capturing this pay-for-performance in a payment to the person or the facility that is responsible to the beneficiary for the delivering the series of care that ends up in recovery, improved function, whatever the case may be.

I don't know how practical it is, but I am saying, get off of trying to rate an institution which is really in another business, people who are in there for eight days or 12 days or whatever the average, 25, and put that accountability and the rewards for it on the professional or the institution that is responsible for the recovery or improved function of the person that is involved, and let them help you develop the measures for recovery.

MR. HACKBARTH: Thank you very much.